ARIZONA DEPARTMENT OF HEALTH SERVICES, OFFICE FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS TBI/SCIJCYSHON BILLING AND INVOICE PACKET
TBI DIRECT CARE SERVICES DETAIL REPORT
CONTRACTOR NAME:
ADHS CONTRACT#
BILLING MONTH:
State Fiscal Year 2008

DATE:

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	2 4 5 6 MEMBER INFORMATION Referral Member Name Date Sex DOB Type of Health Insurance							REFERRALS TO OTHER PAYERS			Reason for	APPROVE	DIRECT	CARE SE	ERVICES APPRO		D DIRECT	CARE SERVICES	APPRO\	APPROVED DIRECT CARE		RVICES	APPROVED DIRE	CT CARE S	ERVICES	APPRO\	ED DIREC	CT CARE S	ERVICES /	APPROVE	D DIRECT CARE S	SERVICES	
FRC Name	Member Name	Referral Date	Sex	DOB	Type of Health Insurance	Insurance or AHCCCS #	Referred Health Plan	Services Requested	Status S	Planned Start Date	denial or delay	Type of Services	# Of Units	Total Cost	Cost per Unit	Type of Services	# Of Units	Total Cost pe Cost Unit	Type of Services	# Of Units	Total Cost	Cost per Unit	Type of # Of Services Units	Total Cost	Cost per Unit	Type of Services	# Of Units	Total Cost	Cost per Unit	Type of Services	# Of Total Units Cost	Cost per Unit	TOTAL
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